1620-V SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

REVISION DATES: 02/01/09, 10/01/07, 09/01/05, 02/01/05, 10/01/04

INITIAL
EFFECTIVE DATE: 02/14/1996

A. Case managers are responsible for ongoing monitoring of the services and placement of each member assigned to their caseload in order to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers.

B. Member placement and services must be reviewed on-site, with the member present, within the following timeframes:

1. At least every 180 days for a member in an institutional setting (this includes ventilator dependent program members, members receiving hospice services and those in uncertified institutional settings)

2. At least every 90 days for a member receiving home and community based services (HCBS)

3. At least every 90 days for a member residing in an alternative residential setting

4. At least every 90 days for a community-based member receiving acute care services only. Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year. Acute Care Only members residing in a non-contracted or uncertified institutional setting must have an on-site visit at least every 180 days, and

5. At least every 180 days for DD members 12 years or older residing in a group home, unless the member is medically involved or seriously mentally ill/severely emotionally disturbed (SMI/SED). If medically involved or SMI/SED, on-site visits must be made at least every 90 days.

Refer to Exhibit 1620-1 for a chart on Case Management Timeframes.

Contractors may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion.

Case managers should attend nursing facility care conferences on a periodic basis as an opportunity to discuss the member's needs and services jointly with the member, care providers and the family.

C. Review visits must be conducted at the member's residence. If an alternate site is used, the rationale must be documented in the case management file. A visit made to a site other than the member's place of residence must be at the request of the member or representative, not just for the convenience of the case manager.

D. Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action. More frequent case monitoring is required when the case manager is notified of an urgent/emergent need or change of condition which will require revisions to the existing service plan.

An emergency visit is required when the situation is urgent and cannot be handled over the telephone and when the case manager has reason to believe that the member's well being is endangered.

E. Case managers must conduct an on-site review within ten business days following a member's change of placement type (for example, from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS) or from the date the case manager is made aware of such a change. This review should be conducted to ensure that appropriate services are in place and that the member agrees with the service plan as authorized.

Whenever possible, discharge to a member's own home should be delayed until adequate services can be arranged. In-home services must be initiated within ten business days following a member's discharge to HCBS.

F. If the case manager is unable to contact an enrolled member to schedule a visit, a letter must be sent to the member or representative requesting contact by a specific date (ten business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the case manager must complete a Member Change Report Form (Exhibit 1620-2) indicating loss of contact and forward this, along with a copy of the letter, to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program.

NOTE – Disenrollment will not occur if the local office is able to make contact with the member or representative and confirm that the member does not wish to withdraw from the ALTCS program.

G. The case manager must meet with the member and/or representative, according to the established standards, in order to:

1. Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the case manager must take and document action taken to resolve these as quickly as possible. The Contractor administration must also be advised of member grievances and provider issues for purposes of tracking/trending.

2. Assess the member's current functional, medical, behavioral and social strengths and needs, including any changes to the member's informal support system.

   The Uniform Assessment Tool (UAT), used to determine the member's Level of Care, must be updated at least annually, more often as indicated by a change in member condition. Depending on contractual requirements, it may also be updated as requested for nursing facility authorizations. A copy of the UAT may be found in Exhibit 1620-3.

3. Assess the continued appropriateness of the member's current placement and services

4. Assess the cost effectiveness of services provided and/or requested

5. Discuss the member's perception of his/her progress toward established goals

6. Identify any barriers to the achievement of the member's goals, and

7. Develop new goals as needed.

8. Review and document, at least annually, the member's continued choice of his or her spouse as paid caregiver. Documentation shall include the member's signature on the "Spouse Attendant Care Acknowledgement of Understanding Form" (Exhibit 1620-12).

H. The member representative must be involved for the above if the member is unable to participate due to a cognitive impairment, if the member is a minor child and/or if the member has a legal guardian.

   If the member is not capable of making his/her own decisions, but does not have a legal representative or member representative available, the case manager must refer the case to the Public Fiduciary or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file.

I. Members who reside in an institutional setting should be regularly assessed to determine if it is possible to safely meet the member's needs in a HCB setting.

J. The case manager must complete a written service plan (Exhibit 1620-13) at the time of the initial visit, when there are any changes in services, and at the time of each review visit (every 90 or 180 days). The member or representative must indicate whether they agree or disagree with each service authorization and sign the service plan each time. The member must be given a copy of each signed service plan.

K. At the time of each HCBS member's (not including those residing in and assisted living facility) service review, the case manager must review, with the member and/or representative, the Contractor's process for members to immediately report any unplanned gaps in service delivery.

L. The member's HCB service providers must be contacted at least annually to discuss their assessment of the member's needs and status. Contact should be made as soon as possible to address problems or issues identified by the member/representative or case manager. This should include providers of such services as personal or attendant care, home delivered meals, homemaker, therapy, etc.

   If the member is receiving skilled nursing care from a home health agency, contact is required with the service provider more frequently (see Standard XI, Skilled Nursing Need, in this Chapter).

   For members receiving behavioral health services, the case manager may need to make contact with the service provider quarterly in order to complete the behavioral health consultation.

M. The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order (see Chapter 1200 of this manual for more information on which services require an order from the member's PCP).